BOSTON UNIVERSITY
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A SIX YEAR FOLLOW-UP STUDY OF FIFTEEN RHEUMATIC FEVER PATIENTS

A Thesis

Submitted by

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CHAPTER I.

INTRODUCTION

Purpose of the Study

The purpose of this thesis is to study the environmental adjustment made by fifteen rheumatic fever patients upon their discharge from the Church medical foster home and to determine what contributions the foster home made to this adjustment. The writer will attempt to examine the progress made at school and at work as well as the recreational activities engaged in by the children. Consideration will also be given to the following questions: Which personality factors of the foster mother enabled her to understand and cope with some of the behavior problems presented by the children? What particular areas of adjustment were affected by the foster home experience? Which factors hindered the patients' adjustment after leaving the Church home?

Method and Sources of Data

All the records of the children who had been placed in the Church foster home from April 1941 to April 1947 were read. Examination of the records revealed that a total of 121 children, all of them girls, were cared for at the home during that period. The writer found that the cases fell into three categories. The first group, containing eighty-seven

cases, consisted of those children who had been referred, upon discharge, to other agencies for further contact or to their own parents for home supervision by the agency. The second group, containing eighteen cases, consisted of those children who had been discharged directly to their own homes and who had had such varying diagnoses as scoliosis, osteomyelitis, and second-degree burns.

The writer, however, was interested in the third group which contained sixteen cases. One case could not be read because it was marked confidential. The children in this category had also been directly discharged to their own homes from the foster home, but had had diagnoses of rheumatic fever, rheumatic heart disease, and chorea. The writer felt that it would be more valuable to the agency to have information about these children since most of the cases handled by Children's Mission involve rheumatic fever. It also seemed more interesting to consider only those children who were directly discharged to their own homes. During the period of time under consideration in this study there had been only a small number of cases where home supervision had been undertaken by a social worker from the agency. The tendency then was to cut down on this type of supervision because the workers were so pressed for time and also because the agency desired to know how these children would get along without this supervision. Therefore, the writer thought that it might be useful to know what sort of adjustment these children made without home supervision by the agency.

Three schedules were employed in order to collect the information. The first one was used to get material from the case records in the agency's files. The second one was used during several interviews with the foster

mother of the Church medical home. The writer considers herself fortunate to have been able to have had direct contact with her, from November 1947 until the writing of this thesis, in connection with one of her own cases. In this way, first-hand knowledge was gained about the home and about the foster mother's methods of handling the children placed there.

The third schedule was used to secure information during visits made to the homes of the children. Only ten home visits were actually made. An eleventh visit was made but no one was at home. The writer, however, was able to contact the Maverick Dispensary, which is following the case. The social worker there answered many of the questions on the third schedule. Telephone calls were made to two of the four remaining cases because of the distance involved. It was considered unethical to make home visits in connection with the last two cases. One child, who had been discharged, had been readmitted to the foster home one month after April 1947. The other child was working in the foster home at the time of this study. The writer, therefore, spoke to these two girls personally about their school and work adjustments as well as about their recreational activities.

Limitations

Interviewing conditions in the home could not always be ideal. Members of the family often answered for the patient the questions which were asked. In one instance a mother would not allow her child to talk at all.

Lack of time prevented the writer from having direct contact with the schools. At times the writer became aware of the inconsistency between

the records and the patient's or her parents' statements.

It was very difficult for the writer to obtain much information on the home adjustment of the children. Therefore, although a vital aspect, the area of home adjustment had to be omitted. The parents could more readily understand the agency's interest in the school progress or in the health of their children.

In general, the method used by the writer involved a large element of subjectivity on the part of the patients and their parents. The reports on school, work, and recreation are subjective.

CHAPTER II.

THE IMPORTANCE OF RHEUMATIC FEVER

Meaning of Illness to the Patient

The individual as a person has been a source of study, not only in psychiatry and social work, but also in the schools, the churches, the courts and the hospitals. This is revealed by the amount of literature which has been published in the last few years. Such books as the following come to mind: "Peace of Mind", "The Patient as a Person", and "Mind, Medicine, and Man".[1]

Recently there has been a development in concepts regarding psychic and organic aspects of illness and these are being brought together. Psychosomatic concepts stress the relation between "psyche" and "soma". "It is now known that in most instances illness is both functional and organic and that the symptoms presented are in reality an expression of the interaction of the two."[2] "It is not that the emotional aspect must always be the predominant one but that we have not sufficiently in the past seen how it was

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1 Joshua L. Liebman, Peace of Mind, Simon and Schuster, Inc., 1946. G. Canby Robinson, The Patient as a Person, The Commonwealth Fund, 1939. Gregory Zilboorg, Mind, Medicine, and Man, Harcourt, Brace & Company, 1943.

2 H. M. Margolis, M. D., "The Psychosomatic Approach to Medical Diagnosis and Treatment," The Family, 27:292, December, 1946.

interwoven with the others; and failure to appreciate this interrelationship inevitably results in failure of the other--that is, intellectual and environmental--methods of treatment when used alone."[3]

Today social work as a profession is beginning to see the patient as a whole; that is, the individual in his environment. "This growing recognition not only that body and mind are one but also that the patient exists as a member of a family unit and of a larger social environment, makes the contribution of social work more valuable to the medical profession."[4] "We need a growing understanding of what illness means to each individual and familiarity with psychosomatic concepts in medicine as a means of relating our work better."[5] "There was the history, for example, that revealed that the adolescent with rheumatic heart disease lived three flights up and slept in a bed with his two brothers and that the rooms were poorly heated. But as for his reaction to this, little if anything was contributed."[6]

The experience of illness creates a situation for the individual which centers around the fundamental relationships of life and the feelings that accompany it are apt to be vivid and intense in nature. "It is not possible to regard the present behavior of an ill person as divorced from his past. Illness is one of the emergencies of life particularly well

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3 Harriet Bartlett, "Emotional Elements in Illness," The Family, 21:43, April, 1940.

4 Elise De La Fontaine, "Some Implications of Psychosomatic Medicine for Case Work," The Family, 27:128, June, 1946.

5 Bartlett, op. cit., p. 46.

6 Jeanette Hertzman, "Casework in the Psychosomatic Approach," 27:308, December, 1946.

suited to create again the original family situation."[7] The nature of illness itself and the degree of physical limitation inherent in it enforce upon the individual a state of regression in which he is again dependent upon others for the gratification of his needs. When the ill person finds himself among other patients, "it is not surprising that those in charge of his care should assume various emotional roles for him and that fellow patients often are regarded as siblings."[8]

Therefore, the meaning of illness to the individual patient deserves consideration and interpretation. His inability to function normally, both organically and socially, may give rise to dependency or egotistical feelings. The attitude that one is different could easily cause a person to feel superior, or depending upon the need of the person to conform to ways of the group, it could cause strong feelings of inferiority. Contacts with others are not carried on as they formerly were; they may peter out or be broken entirely.[9] The ill person cannot participate as he once did.

"When adolescents and young adults are involved in illness, the picture of emotional strain becomes great. The impact of illness occurs at a time when the individual is expected to be most vigorous, independent, and productive and when he is, under the best of circumstances, required to make many adjustments."[10] A problem may arise when carefully made plans involving school or training may have to be laid aside for a physically less exact-

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7 Eleanor Cockerill, "Adventures in Understanding," The Family, 20:155, July, 1939.

8 Ibid., p. 155.

9 The information was obtained from lecture notes in Medical Information I and II.

10 Evelyn F. Cooper, "Medical-Social Problems of Rheumatic Heart Disease in the Adult," The Family, 28:51, February, 1947.

ing career. Under such circumstances, to begin again on a second choice is difficult and may hold very little motivation for the individual. Consequent conflicts may well lead to anxiety, guilt, and frustration. "Adjustment may be slow or may never be achieved at all."[11]

The emotional response of the sick child to his illness and convalescence is dependent on various factors. Basically, these are the physical, intellectual, and psychological status of the individual at the onset of his illness. Also present are the existing attitudes of the sick child during the period of ill health and his pre-existing fears about illness and life in general. Illness may be a threat to the child in regard to his security, dreams, or ego. Possibly, to some children, it may suggest a fear of separation from his loved parents or life itself.[12]

Extended illness brings many serious problems to the fore. School is the first consideration. If a child is to have a teacher at home, it is important that she be a dependable and efficient person who will adequately prepare the child for future schooling. When the child does return to school, there is an adjustment to be made to the curriculum and a preparation to be made for the acceptance of limitations of physical activity. "An unusual burden in self-care is put on the young cardiac."[13] "The child is primarily concerned with being restored to his former place in society. For this reason the question of social incapacity, whether or not it is consciously understood by the patient, is very important."[14] The child may

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11 Cooper, op. cit., p. 51.

12 The information was received from a discussion with Miss Soddeck, a staff member from Children's Mission.

13 Cooper, op. cit., p. 51.

14 Bartlett, op. cit., p. 43.

make poor social contacts because he has inferiority feelings due to his being "different". He may become socially retarded and withdrawn. On the other hand, he may feel very hostile toward the whole world, not knowing whom to blame for his disability. There is much for him to learn in a social as well as in an educational sense. Since he might have been the center of attention and all his wishes might have been gratified while he was ill, he may find it difficult to become accustomed to the outside world.[15]

In conclusion it can be said that "adverse social factors have significance in medical care chiefly because of their power to disable. These factors expressed as deprivations, strains, and dissatisfactions have physiological effects such as depletion of body substance, fatigue, and emotional tension. These effects seem to be of special importance in aggravating disability already started by organic disease."[16]

Problem of Rheumatic Fever

Rheumatic fever is now generally considered to be a major public health problem. Its cause is still unknown. Although brief in duration, its convalescence is long and the effects may be crippling.[17] A patient often has to reorganize his entire life because rheumatic fever is one of the causes of disabling heart disease.

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15 The information was obtained from lecture notes in Medical Information I and II.

16 Margolis, op. cit., p. 297.

17 J. Hamilton Crawford, "Public Health Aspects of Heart Disease," Part I, Hygeia, 17:139-141, February, 1939.

Although a childhood disease occurring often between five and fourteen years of age, the course of rheumatic fever includes the recurrences of any of the sumptoms in later years. If rheumatic fever attacks early in life, the patient does not have a good chance of escaping these recurrences as well as possible heart damage. If attacks cease after puberty, the patient may be fortunate enough to carry on without more heart damage. There seems to be some correlation between the number and severity of recurrences and the degree of cardiac damage.[18]

Chorea, which is connected with rheumatic fever, is a disease of the nervous system and also affects the heart. It occurs more frequently after ten years of age and is rare after puberty. The onset may be gradual with signs of great irritability. When an attack is severe, it is characterized by sudden irregular, aimless movements accompanied by general muscular weakness. However, even a mild attack of chorea may be associated with severe rheumatic heart disease.[19] Chorea runs a course of six to ten weeks.

Cause of Rheumatic Fever

Since nothing is really known about the cause of rheumatic fever, we only have some of the theories to consider. Hemolytic streptococci have long been suspected of playing an important role. The streptococcal infection appears to constitute the contagious element in rheumatic fever. Children with rheumatic heart disease must be guarded against such infection,

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18 Crawford, op. cit., p. 155-156.

19 Edward L. Bauer, "Rheumatic Heart Disease in Children," Hygeia, 20:306-309, April, 1942.

for recurrent attacks of rheumatic fever may occur. How streptococcal infections lead to rheumatic fever is not clear but it has been found that the disease often occurs after attacks of scarlet fever, tonsillitis, or upper respiratory infections for which hemolytic streptococci are responsible.[20]

Studies have shown that there is a relationship between this disease and environmental factors. Children who live in crowded, unhealthy houses and who suffer from poor nutrition are potential patients. The disease also tends to occur in certain families. Some authorities believe this to be on a hereditary basis, while others point out that the possibility of contagion cannot be entirely ruled out. In the spring the streptococci are more prevalent because of the changeable weather. Therefore, rheumatic fever tends to occur more frequently during that particular season.[21]

Rheumatic fever has been found difficult to diagnose because its symptoms are noticed in connection with other diseases. Symptoms may include high fever of unknown origin, nose bleeds, swelling and pain in the joints, subcutaneous nodules, and unusual loss of weight.

Treatment

The most important method of treatment is bed rest. It is feasible to use this method both in the acute phase as well as in the slow chronic stage. In order to reduce the fever and give some measure of relief of pains salicylates are administered. There is little known regarding the use

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20 Phyllis B. Koehler, "Rheumatic Heart Disease--Pied Piper of Youth," Hygeia, 16:503, June, 1938.

21 Ibid., p. 503.

of drugs and their effect on the course of rheumatic fever. The length of each recurrence varies from just a few months to as much as several years. Good nursing care and a comfortable environment are essentials during the long periods of illness.

Acutely ill children usually can be given proper care in a hospital which has adequate facilities. When the acute stages have passed and the child still needs convalescent care, a foster home or convalescent institution should be considered if the parents' home is not suitable. In either event, follow-ups should be made by way of prevention of future illness. It must be recognized that individualized treatment is necessary. Recognition of the meaning of illness to the child and his parents is important also.

Prognosis

The vital factors in the prognosis of rheumatic fever are the presence or absence of active carditis, the number and frequency of attacks, the degree of permanent heart damage, and the age of the patient. Any conclusion must be tentative because of lack of knowledge regarding the incidence and severity of the disease.

A significant number of rheumatic fever patients escape serious heart damage and the outlook for them is very good. However, persons with rheumatic heart disease can lead useful lives. Those who have a mild impairment but who take proper care of themselves can expect to live about as long as if they did not have the disease at all.

Function of the Agency

At present the Children's Mission to Children holds an important position in the community. This is because of its program of service to children. The agency provides specialized foster home care for children with medical problems or those convalescing from illness. Most of the cases which are handled by the agency involve problems pertaining to rheumatic fever and chorea. The social workers are well aware of the fact that once rheumatic fever strikes, the patient usually needs prolonged medical care and in most instances has certain adjustments to face at home, in school, in play, and in choice of a vocation.

The Children's Mission is also interested in the progressive developments in local child care planning and has maintained an interest in methods of social treatment of children with medical problems. The staff is always co-operating in the prevention of recurring health problems.[22]

Role of the Social Worker

The role of the social worker in a medical agency, such as Children's Mission, is a very important one. She has relationships with many people in connection with just one case. She interprets the meaning of the disease to the patient and tries to understand what the resulting problems will represent to him. She informs the doctor, after an investigation of

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22 The information in this chapter was generally gained from observation, experience, and discussion with several members of the staff, as well as from lecture notes in Medical Information I and II.

the social status of the patient and an evaluation of the significance of adverse social conditions, about the social and emotional factors, thereby individualizing the patient for him. She also aids in carrying out the various medical recommendations. A good interpretation to the patient's family, relatives, and friends, as well as to the community, is a vital part of her work. The social worker finds it necessary to discuss each case fully with the foster parents in order to give them greater understanding. In addition, it is her duty to see that the function of the agency is carried out.

The social worker has the most contact with the patient and the foster parents. "The capacity to identify with the patient, to understand his need, and to give him genuine acceptance may be a dynamic element in the social treatment."[23] "Once the rheumatic patient's range of activity is defined it cannot be regarded as static."[24] Rheumatic heart disease is progressive and repeated attacks of acute rheumatic fever may frequently result in additional heart damage. There is a possibility that in a given patient dependence and regression, which are frequently characteristics of the ill person, will not be shaken off after each succeeding attack. Therefore, the social worker judges the patient's resilience. She is sensitive to the point at which the patient shows discouragement and defeat. Her support and reassurance often help the patient to avoid prolonged dependence on his family or community. The social worker helps the patient and his family to understand that a wide range of physical disability is included under the

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23 Bartlett, op. cit., p. 44.

24 Cooper, op. cit., p. 52.

diagnosis of "heart disease". She explains the necessary limitations but also points out the ways in which the patient can continue to live as he did in the past. In general, the social worker provides a sustaining relationship with reassurance, acceptance, and permissiveness.

The relationship between the social worker and the foster parents is one of partnership. The foster parents are considered to be professional people who have to be oriented to the ways of the agency. Supervision, both social and medical, is given by the social worker to the foster parents in an effort to assist them by putting professional techniques at their service and by an interchange of ideas to reach a better understanding of the patient and of the ways in which to help him. Above all, the social worker gives recognition to the exacting nature of the foster parents' task.[25]

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25 The information in this section was obtained from a discussion with Miss Sanborn, Head Supervisor of Children's Mission.

CHAPTER III.

THE CHURCH MEDICAL FOSTER HOME

Importance of Home Life

The family is the foundation of our way of life and constitutes the basic unit which can give to society mature, emotionally healthy, alert citizens. Therefore, in a choice of a foster home the hope is to guarantee the child an experience of real family relationships, individualized care, love, and security. Of course, the child's own home should be the first consideration. For many reasons, however, convalescent care may not be possible for a child in his own home. Such things as poor housing conditions, emotional instability or limited intelligence of the parents, little understanding of the child's needs, inability to provide constant care and supervision, and inaccessibility to expert medical service are very disturbing factors.

The Children's Mission has realized the importance of carefully selected foster homes. Especially high standards have been set up in regard to the medical homes, of which there are two, which offer bed care and medical attention beyond that which can be supplied within the child's own family setting. Children between the ages of two and twenty-one are placed by the Mission. However, those with infectious diseases, with personality and behavior difficulties where the medical problem is not primary, and with deficient mentalities are not accepted. They are usually referred to

agencies whose function it is to care for these children. The foster parents are always given a social summary which describes the child's personality, family, home, school background, and medical history.

Placement in the foster home is continued until the rheumatic infection has subsided. The evidence used to substantiate this fact is a normal sedimentation rate and white blood count, a disappearance of the subcutaneous nodules and joint pains, and an absence of choreiform movements. At first the child is on complete bed rest, but may have school lessons and occupational therapy. Then, the child is allowed to have some time out of bed. This time is carefully regulated and gradually increased as is indicated by the improvement made.

Physical Description of the Church Home

The Church medical foster home is located at 3 Egremont Road, Brookline, Massachusetts. The house is built on a slight elevation. Many windows allow for sufficient sunlight and fresh air. There is some ground around the house so as to provide yard space for outdoor activities in nice weather. It is a good neighborhood, consisting of small private dwellings. The home is near anough to Boston so that the services of the Children's Mission's physicians are readily available.

There are nine rooms of which three serve as bedrooms for the fourteen children. The children are usually arranged according to age groups and each child has a separate bed. Only girls are accepted in this home. There are adequate bathroom facilities on the same floor with the bedrooms.

A fourth room is set aside for isolation purposes. However, the child is not entirely alone since one of the assistants to the foster mother sleeps there also.

Discussion of the Daily Routine

The children are in various stages of convalescence, from complete bed restrictions to "up" care. Nevertheless, rest periods are carefully observed. The children are able to accept limitations because these are accepted by the group around them. Daily temperature and pulse charts are kept as well as records of noticeable symptoms. The foster mother can call the agency's medical director at any time, providing that she first gets in contact with the social worker of the child. No medication is ever given without his advice.

Each child is supervised by a case worker who visits on an average of once a week. Problems which arise between visits are discussed by the foster mother with the worker. The worker can also feel free to give a certain amount of interpretation regarding the child's family and background because the foster mother has much understanding and sensitivity.

Bedside teaching is furnished by the Boston School Department. Five times a week two teachers arrive to spend three hours a day with the children. This schooling is very important. It helps the children keep up with their work so that upon discharge they can be promoted to the next grade. It gives them a feeling that they are pretty normal and able to do something which other children, on the outside, are doing. It obliges them

to spend a good part of their time engaged in a useful activity.

Twice a week the occupational therapist comes with movies, finger painting, sewing, and embroidery. The work, which she initiates, is carried on between visits by the children under the supervision of the foster mother. The occupational therapist keeps notes on the type of work done by each child. At the end of a contact she writes up an evaluation report.

Special teachers come to the foster home in order to give religious instruction. The foster mother herself has a keen appreciation of spiritual values and of the need to train children in accord with the faith of their parents.

Saturday is visiting day. No more than two persons may see a particular child and no one under sixteen years of age is allowed at all. The foster mother speaks with the parents and contributes to their understanding of the child's illness. She tries to point out the fundamental rules to be followed when the child returns home.

Evaluation of the Foster Mother

Mrs. Jean Church, the foster mother, is fifty-seven years old. She and her husband, who died in 1947, came from Nova Scotia to the United States during the depression. She had been a school teacher and he a farmer. They had had two children but the son was killed in World War II. The daughter is married and has two small children of her own. While her husband was in the army, she lived in the foster home and shared the work and responsibilities with her mother.

The children affectionately call Mrs. Church "Mumsie". She has a warm, motherly personality but is not oversolicitous. Although kind and understanding, she shows firmness about carrying out the rules set down by the medical director and the Children's Mission. She has a good knowledge of the emotional factors in illness and is conscious of the possibility of regression into infantile patterns of behavior. She attempts to prevent utter dependency. She tries to accept the child's parents and co-operates in strengthening home ties.

The agency has found Mrs. Church to be very reliable medically. She is alert to symptoms and her intuitions, judgements, and reactions to the children are almost always accurate. She is able to follow the physician's directions and recommendations. It is of value to the agency to read the notes which she has taken concerning each child.

As a person, Mrs. Church is gracious and charming. Her administrative ability is exhibited in the smooth-running machinery of her household. In difficult cases, where anxiety is inevitable, she uses the help of the social worker in order to share the responsibility. The agency can count on the fact that in an emergency she will remain calm.

CHAPTER IV.

ADJUSTMENT OF THE RHEUMATIC FEVER PATIENTS

Education of the Fifteen Patients

"Worries over school retardation are common among patients. In the early period, promise and explanation of the home teacher's service, and of the auxiliary educational services, are reassuring."[1] It is the accepted thing for each child, when he reaches the proper age, to go to school. This gives him the feeling that he is a part of society. A child who is ill or convalescing may feel a real deprivation if he is not allowed to participate in the daily activity of going to school with his friends. A great deal of support and definite plans for schooling are important for the rheumatic fever patient who may feel physically well enough to go to school.

The terms "home teacher" or "visiting teacher" in this study refer to the teacher who came either to the homes of the children or to one medical foster home. Since the visiting teachers come to the Church home five times a week, they are known to the social workers as well as to the foster mother. In this way much knowledge and interpretation can be exchanged.

Eleven of the fifteen children received schooling at the foster home. There were four who did not receive any instruction. Two of the four had short-term placements and the other two came during the summer months. For

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1 Virginia B. Ebert, "Case Work Services to Children with Rheumatic Heart Disease," The Family, 22:13, March, 1941.

the eleven children schooling was part of the daily routine. They enjoyed the novelty of being in bed and having the teachers come to them. Each child was inspired to do his homework because it was at the same time as her fellow students. This type of education is informal with children being able to speak up when they please and assignments being easy enough so that the strength of the children is not taxed too much.

However, children often find difficulty when they return to school. A home teacher cannot possibly cover school subjects as thoroughly as does the teacher of a regular class. When a child spends a great deal of time in bed, he needs skilled teaching and an education which is related to his eventual return to the probable competition of a regular class.

In the group of fifteen, it is known that eight are still in public school, three are still in high school, two are high school graduates, and one left school after completing two years of high school. The remaining child was readmitted to the foster home on April 21, 1947. There she is receiving education on a public school level.

All of the children attending school, with one exception, were promoted after their discharge from the foster home. Eight of the children in this category have attended their classes regularly. One child, however, has a modified program on the recommendation of her doctor. She goes only half a day. Three children have not gone to school on a regular basis. The child who is at present back in the foster home also did not attend school regularly previous to her readmission. Six of the children in the category under consideration found the subject of arithmetic very difficult upon their return to school. They had not had this trouble while at the foster

home. This fact is not easy to evaluate.

Many factors enter into the length of education at regular school in the individual case. These factors are intelligence, health, and ambitions of the patient as well as environmental conditions, economic need, and parental pressure.

This case illustrates how a disturbed family background prevented a good school adjustment before placement and how the foster home experience influenced this situation. This case is one of five other cases where the same problem existed.

A. G., aged eight, is a middle child amidst a family of ten children. The case record indicates that throughout her young life she constantly made bids for attention. She has a tendency to show off a great deal in her hunger for affection. The father deserted many times and was frequently drunk when at home. The mother had many affairs during his absences and there is a question of the legitimacy of the children with different men involved.

The house in which the family lives is in a poor neighborhood. It is a wooden structure which retains the cold and dampness of the air. It is a cold water flat with drafty floors and windows.

A. G., at the age of six, was placed for a seven-month period in the foster home with a diagnosis of rheumatic fever and rheumatic heart disease. Her illness was not in an acute stage while there and she made a good recovery. When she first came to the home, she was quick-tempered and destructive. She liked to poke fun at the other children and would cry and screech when she could not have her own way.

The foster mother quickly recognized that A. G. was starved for love. After an interpretation from the social worker, she realized that A. G.'s behavior reflected the deeply disturbed marital background of her home. The foster mother showed warmth toward the child and praised her for even small accomplishments in order to lessen her feelings of rejection and inferiority. This was a new experience for A. G. and its effect was evident in the great improvement in her behavior and school work. She made excellent school progress.

During the home visit, the writer learned that A. G. had been promoted upon discharge from the foster home. She attends school regularly and was only absent for a period of two weeks with an abscessed ear. At first, apparently, there had been some regression, but at the present time

she seems to have made a satisfactory adjustment. She spoke to the writer with enthusiasm concerning school and there was no evidence of her previous boredom and dissatisfaction.

This case was given in toto despite the fact that the role of the foster mother is discussed further on. The reason for this was to give the reader a more complete picture of the interaction of emotional, mental, and physical factors. The evidence seems to indicate that the foster home experience gave the child the necessary rest and security which enabled her to continue to do well in her studies even after her discharge to her own home. Even though she was again a middle child in the group, she could accept this position because of the status given to her by the foster mother. This feeling of personal worth seems to have stayed with her to some degree and she is now more able to face her own siblings.

The following example is presented here to illustrate how children, suffering from a long illness which recurs several times, may have their schooling interrupted. It is not typical of the other cases in the study because this child was the only one of two children who had a home teacher and did not return directly to school after discharge.

A. O. was eleven years old when she was admitted to the foster home with a diagnosis of chorea and potential rheumatic heart disease. Previous to this admission, her school attendance had been quite irregular but her work had been good. The teacher at the foster home, however, found that while she had ability, her school work was not consistent. There were swings from good to poor work depending on her emotional and physical condition.

After a period of seven months, on April 12, 1946, she was discharged from the foster home. The doctor suggested that she have a home teacher until June of that year because she was actually not well enough to undertake regular school life. During the summer of 1946, A. O. had recuperated and was looking forward to September and to the classroom.

Unfortunately, she had a relapse in the fall and was immediately referred to the hospital where she stayed until May 1947. Throughout her

entire stay at the hospital she had the services of a visiting teacher. In September 1947 she started going to junior high school. During the home visit the writer was informed that A. O. has been on the honor roll since January 1948. She was not having difficulty with any subject and was trying to avoid missing days in school.

This case will be further discussed when the writer takes up the foster mother-child relationship. However, it is already evident from what has been said that there is a connection between school achievement and emotional problems which beset the patient. Certain stresses in the foster home caused the quality of A. O.'s work to go down.

Of the children who returned to school after discharge, there were only two who had a difficult adjustment. The following evidence seems to indicate that there was a lack of understanding on the part of both the principals and the teachers.

A. L. was thirteen years old when she was discharged from the foster home. Her diagnosis had been acute rheumatic fever with choreiform movements. During her stay at the foster home she suffered a great deal. Her attacks of chorea were so bad that at times she was unable to walk or feed herself or even control her bladder. She had poor skin and teeth and was underweight.

The foster mother stated that A. L.'s school work showed conscientious effort. The visiting teacher had told the foster mother that A. L. could not be pushed too much because of her physical condition. Upon discharge, the doctor advised A. L.'s mother to engage the services of a home teacher. This was done and the teacher came for a period of two years.

Finally, A. L. returned to regular school but her experiences there were very unpleasant. Her teachers punished her for being slow in adapting to the school routine. She was scolded and often made to stay after the other students had left in order to complete some work. Several teachers were determined that A. L. was taking advantage of her illness and deliberately staying out of school when the weather was not good.

Although her attendance was not very regular because of her illness, she did work hard in order to be graduated from public school. During the home visit, A. L. told the writer that she was in the first year of high school and was on the honor roll. She was much better physically and could take gym.

This case illustrates the fact that school, after a long convalescence, can be a harmful experience if the teachers of the patient do not have the understanding nor the knowledge regarding the illness suffered by the patient. If these teachers had known about rheumatic fever and its emotionally as well as physically crippling effects, they would have been more thoughtful in their approach. They seemed to show no comprehension of the fact that A. L. had been trained in the foster home to avoid bad weather and to take precautions about colds. The social workers of these children could have assisted in these instances by interpreting the children's condition and limitations to the teachers and principals. The fact that A. L. did enter high school and is doing so well seems to indicate that she does have the necessary capabilities.

A. I. was twelve years old when she was admitted to the foster home for the first time and was fourteen years old at the time of her second placement there, which occurred just after April 1947 and is, therefore, not within the realm of this study. While at the foster home she made very little progress in her school work.

Upon discharge in September 1946, she returned to school where she was "pushed" a great deal by her teachers. Apparently, she had experienced a similar pattern throughout her entire school career. Although her I. Q. was low, she was put into regular classes and promoted at the usual intervals even though the quality of her work did not warrant it. She was under pressure all the time and this left its mark on her physical and emotional well-being. It was thought by the doctor and by her social worker that A. I.'s school experience was an important factor in the return of her chorea attacks.

The writer has heard several staff members from Children's Mission say that choreiform movements may become a habit or a reaction pattern to a threatening situation with which the patient cannot cope long after the illness itself has disappeared.[2] The above case seems to substantiate this

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2 The information was obtained from a discussion with Mrs. M. Carden, Miss C. Davis, and Miss E. Soddeck, who are staff members of Children's Mission.

theory. In this situation the threat lies in the school experience. If intelligence tests had been given as soon as it was recognized that A. I.'s work was not up to par, she might have been spared a great deal of anxiety. After her exact level of mental ability had been determined, she could have been placed in a special class which would have met her needs.

Work Experiences of Three Patients

The patient and the members of his family are usually anxious about what sort of a job the patient will be able to get when he is ready to work. They need reassurance that the patient can live a normal life if he co-operates in adjusting himself to certain limitations. Right at the start of the family contact the social worker begins to stress the more positive rather than the negative aspects. It is true that patients with a severe heart condition are barred from some occupations. However, if the patient has done well in caring for his health and has not developed much heart damage, there are no special restrictions as far as jobs are concerned beyond the prohibition against laborious work.

Only three girls of the group of fifteen are now at work. They have not found their jobs to be particularly exhausting, either physically or emotionally, beyond natural fatigue. They were proud that they were working and supporting themselves. In all three cases the jobs were considered good and "just what we wanted". The physical conditions of the girls seemed not to have stood in the way of their securing the jobs they desired. In only one case, however, was the writer able to determine the effect of the

physical handicap on the quality of work done.

The following cases give a picture to the reader of the kind of adjustment that was made by the three working girls.

A. F., aged twenty, was placed in the foster home with a diagnosis of rheumatic fever, rheumatic heart disease, and acute anterior poliomyelitis in the subsiding phase. Her own family background was confused and it was learned from the record that she had been a neglected child. The parents were dead and she lived with an older, unmarried sister who worked. A. F. spent much of her life in various hospitals but, somehow, managed to complete two years of high school.

While in the foster home, she conscientiously performed exercises which eventually helped her to walk and move her arms. The foster mother felt that A. F. was pretty well adjusted to her illness and said that she displayed a well-balanced, stable, and light-hearted personality. This fact together with her complete recovery from active rheumatic fever as well as poliomyelitis undoubtedly helped her to secure a job.

During the home visit, the writer learned that A. F. was working in a laboratory sorting and packaging pills. In high school she had taken a few chemistry courses which, she felt, helped her in her job. She found her fellow employees pleasant to work with but because of her apparent shyness, she did not see them on a social basis. She was happy about the fact that although she still lived with her sister, she was, nevertheless, making enough money to support herself.

This girl is fortunate because her recovery was remarkable. She likes her work and it is not too strenuous for her. Her adjustment seems to have been good.

A. M., at the age of nineteen, was placed in the foster home for a short period of time with a diagnosis of rheumatic heart disease and slightly enlarged heart. While there she was friendly, co-operative, and quiet. She got along well with the other girls and was liked by everyone in the foster home.

At the time of the home visit A. M. was twenty-five years old and firmly established in her job as a stitcher in a clothing factory. While attending Practical Arts High School, she learned how to sew and embroider and grew to love this type of work. She stated that she got on well with her employer and fellow employees.

This girl has not had any trouble with her heart nor any recurring attacks of rheumatic fever. Her high school training and good health as

well as her pleasant personality all helped in the acquisition of a job which A. M. liked.

A. B., aged fifteen, was placed in the foster home with a diagnosis of recurrent rheumatic fever, but with a normal heart. This was her second and last attack. There was marked acne on her face and she was quite obese. She stayed at the foster home for a period of eight months which gave the foster mother a chance to become quite well acquainted with her.

The writer received a clear picture of her personality which was described both in the record and by the foster mother. A. B. was very mature for her age and enjoyed the company of older girls and adults. She was friendly and thoughtful, poised and self-assured, and had definite leadership qualities. The foster mother found her almost abnormally efficient and somewhat aggressive and defensive at the same time. A. B. did not allow the foster mother to get very near her in an emotional sense. Therefore, because A. B. kept all her problems to herself, there could be only superficial discussions between the two.

A. B. was slightly objectionable socially because of her affected manner. She showed much interest in school work, friends, clothes, and books. She was bright and alert and used her endowments in order to attract attention and praise. It was thought by the social worker that A. B.'s smooth manner was a means of covering some unhappiness in her background. The foster mother stated that it would have been a relief to see A. B. get really angry because if A. B. was ever upset or dissatisfied, it did not show.

The foster mother did find A. B. helpful with the other children. She had good judgment and was level-headed in an emergency. A. B. did such beautiful work during the time devoted to occupational therapy that the foster mother felt she could have instructed the other girls in this type of work.

After discharge, A. B. completed her high school education. It was a little difficult for her to get used to the routine of school classes but she did attend regularly. The foster mother decided at that time if A. B. were willing, she would be glad to hire her as an assistant in the foster home since there was a vacancy for that job. A. B. accepted this position. Because of her personality and ability with the children, she has been successful. The girls look up to her and since they know her background, feel that they want to obey her because she is one of them.

Recreational Activities

"The cardiac must voluntarily limit his activity even when he is feeling well and there is no indication for restrictions."[3] Especially during the convalescent period, it is wise for the patient, who has heart damage, not to engage in too strenuous recreational activities. However, recreation is an integral part in the life of children. A good adjustment in a group setting makes for greater social ease later on in life. Recreation provides a healthy outlet for excess energy and teaches the child that play for the good of the whole team is more important than play for the good of the individual player.

Eleven of the children do not belong to any clubs at the present time. The reason given to the writer is that there are no recreational centers in the neighborhoods of these children. If there had been home supervision by the agency after discharge, it might have been possible for a social worker to have helped the children find suitable recreation. They have had to resume old friendships or make new acquaintances since their discharge from the foster home. This group as a whole regretted the fact that there were no recreational facilities available. The mothers of two of the children would not allow them to go further than a block or two from their homes in order to play with other children. Apparently, they were concerned lest the children engage in activities which taxed their strength too much. Another child had a difficult time in resuming friendships because she had been gone from the neighborhood for a long period of time. She felt that the others thought of her as an outsider and it was only through sheer persistence that she regained her status in the "in-group".

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3 Cooper, op. cit., p. 52

Two other children of the eleven met with an unexpected problem which hindered their immediate social adjustment in their respective groups. Many of their friends insisted that rheumatic fever was contagious and, therefore, no one would play with them. This situation was remedied when the mothers of the two children convinced the mothers of the neighborhood that rheumatic fever could not be transmitted from one person to another through contact.

The writer found that the four remaining children were fortunate in having available recreational facilities. The following cases will illustrate this.

A. E. is at present sixteen years of age. She had come to the foster home with a diagnosis of chorea. As a result of this illness the doctor refuses to give his permission for her to take gym, even though there is no evidence of choreiform movements. However, she has joined the Walpole Youth Center. She goes there mostly on Saturday nights in order to participate in the social dancing.

A. M., who was discussed in connection with her work experience earlier in this chapter, is now twenty-five years old. The doctor found it necessary to restrict her in the area of sports because of her slightly enlarged heart. Nevertheless, she became a member of the Y. W. C. A. There she attends classes in psychology and photography. She finds these subjects very stimulating and often brings home books from the library to further her knowledge in these two subjects.

A. N. had been placed in the foster home with a diagnosis of rheumatic heart disease and heart murmur. She is now ten years of age. The housing project in which she lives has organized an art club which meets every Thursday in the basement of one of the houses. This club is for children of the project who are nine years old and up. A. N.'s opinion is that drawing is the most fun. However, she also participates in the dancing and singing.

It was fortunate for A. N. to find a club where she could gain some security. A. N. is the oldest of three children but her younger sister, who is more attractive and appealing, is the favorite. A. N. needs every opportunity to show that she also has personal worth. Since she does have some artistic ability, she will find a place for herself in the club and perhaps

gain some attention and recognition for her work. It is possible that this club experience will be some compensation for the subtle rejection she feels at home.

A. I., who was already discussed in connection with her school experience, is back again in the foster home. She is now fifteen years old and an avid fan of Frank Sinatra. When the Sinatra clubs were formed she became a member. Through this club she has acquired many "pen pals" who write to her from various parts of the United States. She keeps in touch with Sinatra's secretary in Hollywood, who sends her on request and some money in coin different articles with Sinatra's picture on them.

Even though this girl is mentally very limited, she is able to write pleasant letters. The writer has read some of the answers to her letters and these responses seem to indicate that A. I. is an interesting correspondent. Because of the greater stimulation, it is perhaps possible that she might absorb more facts about people and their way of life through this letter-writing activity than she could through her formal schooling. The more vital aspect, however, is that she might gain a sense of importance and lose some of her inferiority feelings.

Foster Mother's Approach to Emotional Problems

Illness creates again, for the individual, the original family situation because his present behavior cannot be separated from his past. Therefore, it is not surprising to find that when the patient is among other patients, he assigns various emotional roles to those who care for him and to those around him in other beds. He expects to be treated in the samy way as his parents and siblings treated him. When a child is stricken with a prolonged or crippling illness, his parents become afraid for him and this

fear may result in an oversolicitous attitude. The child may exploit this solicitude. It may seem to him that his illness has given him the right to make demands and have them satisfied. The child is brought into a state of regression where he is dependent on others for gratification. Since this is a pleasant state, the child may resent any attempt to bring this situation of constant gratification to an end. Eventually, he may accept the reality of the situation and continue with his development, but a certain reaction pattern has been laid down.[4]

This may lead to a new reaction pattern on the part of the patient's parents. They may continue their solicitude even when the child is well and may become alarmed when he shows any slight symptoms of illness. This reinforces the child's pattern. Then, if he meets a disappointment in later life, he may react by becoming ill. Frequently, much the same symptoms which he had in childhood during illness appear.[5]

Recurrence of illness emphasizes the disturbances in emotional adjustment just mentioned. Therefore, it would be most desirable to find a way to prevent these illnesses. However, in many instances, notably rheumatic fever, preventive medicine has not made the necessary discoveries. It would seem then that an essential part of the treatment of a child with a serious illness should lie in the management of his convalescence. Kindly and firmly he should be encouraged to derive pleasure from the things he can do for himself. On the other hand, the gratifications he obtains from illness should be reduced to a minimum.

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4 This information was obtained from lecture notes in Development of Personality.

5 This information was obtained from lecture notes in Psychosomatic Medicine.

The foster mother of the Church medical home has had to face problems similar to those just described. In addition, she has had to contend with the whims of a few of the children's parents. These parents criticized the medical care given to the patients, compared the Church home to other foster homes which they had heard about, and often insisted on visiting the children when they, the parents, had colds or sore throats.

The age range of the children in the home during the six year period was from five to twenty years of age. The children came from various cultural backgrounds. These two factors caused the group to be heterogeneous. Yet the foster mother, because of her knowledge, understanding, and skill, was able to organize the group and give it some sort of uniformity which is important for the "we-feeling".

The foster mother has had to handle anything from bad behavior to questions on sex. Usually the information on sex was discussed in the group when particular questions arose which were of general interest to everyone. There was often difficulty in this area because some of the mothers did not feel their daughters should know about marriage and childbirth until the last moment. The foster mother had to find the happy medium between answering questions honestly and avoiding the wrath of the parents. This required much tact and diplomacy, which qualities the foster mother has demonstrated that she possesses. Nine of the fifteen children have continued to keep in touch with her through Christmas cards, telephone calls, and visits. This might indicate that theirs was a pleasant and worthwhile experience at the foster home.

The following cases are presented here in order to point out specifically how the foster mother approached the various emotional problems which

she encountered while the children were in the foster home. The foster mother was active in another case, that of A. G., but this was already discussed in connection with schooling at the foster home.

A. I., who was discussed earlier in this chapter, is the youngest of four children. Her family is poor and she is especially ashamed of her mother who speaks a broken English. She had other foster home placements before she was referred to Children's Mission and placed in the Church home. Her diagnosis was rheumatic fever, rheumatic heart disease and chorea and she has been sick all her life.

In her own home she had little self-determination because her brothers always liked to tell her what to do. There has been a constant conflict between A. I. and her mother and no one quite understands the root of it all. Her father is a very strict and rigid person who believes that A. I. should not receive the affection of her parents automatically but should earn it.

The foster mother knew how to handle A. I. after an interpretation of her background from the social worker. The foster mother realized that while A. I. was emotionally immature, she was very mature in her physical development. Because of her family's attitude she was being kept a baby. The foster mother gave A. I. certain little jobs, such as ironing and cleaning, which gave A. I. a sense of responsibility and worth and yet did not make demands on her mental capacities. Since the foster mother was a warm, attractive, kind person, and very much unlike her own mother in graciousness, A. I. relaxed. While at the foster home, she had hardly, if any, chorea. Yet in her own home the choreiform movements were so bad that she was often incapacitated for short periods of time. The foster mother felt that becoming ill was A. I.'s way of escaping both from her family and from school.

The foster mother found that A. I. was a quiet, obedient child. She was an able worker when given the chance and also did beautiful sewing and embroidery for the occupational therapist. The foster mother tried to bring out the strong features of A. I.'s family and generally wanted A. I. to feel that her own home had much good in it.

Because of her physical maturity, A. I. early developed an interest in boys. The foster mother gave her sex education and tried to utilize this opportunity to make A. I. realize the necessity of personal cleanliness. A. I. began to take better care of herself and her clothes in order to be more appealing to other people, especially boys.

When A. I. was discharged from the foster home after a stay of nine months, her chorea began all over again. She missed the foster home and the life there so much that she phoned there every day at noon for several months. Her chorea became so bad that she was readmitted seven months after

her discharge.

The foster mother helped A. I. to cope with the constant change in social workers. During her first placement there had been four different workers. This gave A. I. a sense of insecurity which the foster mother has been able to combat successfully.

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A. K., who was eleven years old when she was placed in the foster home, had a diagnosis of acute rheumatic fever and some evidence of chorea. She is the oldest of four children. Her father drank quite a bit and her mother was a very untidy person. The parents often quarreled because the father had strong feelings about a well-kept house and the mother was not a very neat or capable housekeeper. The mother was anxious about two things concerning A. K.; one was that she did not eat well and the other was that she was inquisitive about sex.

When A. K. was placed, her mother explained A. K.'s eating habits to the foster mother and spoke of the difficulty she had in making the child eat. The foster mother quickly realized that forcing the child to eat would never solve the problem. Therefore, throughout her placement, the foster mother never urged A. K. to eat; in fact, she ignored A. K. during meals. After a short while, A. K. began eating better and soon looked like a healthy child.

The foster mother found that A. K. wanted a lot of questions answered regarding menstruation and childbirth. The social worker had explained the mother's feelings on this subject. Therefore, the foster mother did not give A. K. individual information. Instead, she drew her into group discussions whenever questions were asked about sex. In this way A. K. satisfied her curiosity and at the same time realized that sex was not a shameful nor secretive thing.

The foster mother was not very successful, however, in teaching A. K. to be more tidy, for in that respect she resembled her mother. The foster mother felt that that habit was too well ingrained in A. K. and could not be entirely broken down in a three month period.

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A. P. was placed in the foster home at the age of thirteen with a diagnosis of chorea. The parents were rejecting of her and preferred her sister. The father was always drunk and the mother tried to push A. P. in every area, especially school, in order to keep up with her sister. Consequently, A. P. was jealous of her sister and verbalized this feeling by saying that the sister always had good health and could have lots of fun engaging in sports.

While at the foster home, she displayed the following characteristics. She did not join in actively in conversations with the other children.

She seemed somewhat retarded and very shy. Usually, she was helpless even in the face of small obstacles. She was not very talkative with the foster mother nor with her social worker.

The social worker, in interpreting the child to the foster mother, brought out the fact that A. P.'s mother was ashamed for her daughter and, therefore, rejected her. Yet because of her guilt at having this feeling, the mother overprotected the child. Therefore, A. P. had little experience in doing things for herself or in making her own decisions.

The foster mother displayed warmth and kindness to her and slowly she overcame some of her shyness. She again used the technique of giving A. P. small duties in order to make her feel important and needed. The foster mother also placed A. P.'s bed near a very stable girl in the home. Since A. P. had little initiative of her own, she followed the ways of the other girl and the two became good friends. The foster mother stated to the writer that she felt this was A. P.'s first real friend.

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A. O. was mentioned previously in this chapter in connection with schooling. She was eleven years old when she was placed in the foster home with a diagnosis of chorea. She is one of thirteen children. The mother is a strong figure who tries to keep the family together during the times that the father deserts.

At first there were no problems with A. O. She was pretty, charming, and a good conversationalist. However, after a short time, she displayed a negative attitude, was rude to everyone, and did not co-operate with the routine. After studying the situation for awhile, the foster mother detected that it was the girl in the next bed who was disturbing A. O. and that a neurotic relationship existed between the two. A. O. and A. P. had known each other in the Boston City Hospital. A. P., because of her own needs, made fun of A. O.'s mother's visits in jealousy over the fact that her own mother never visited. The foster mother moved the two girls apart but the difficulties continued to some extent. The two girls wanted each other's friendship and, yet, when together, brought out the worst in each other. It definitely seemed like a sadistic-masochistic relationship.

A. O. carried on a constant fight for love and attention and was repeating a pattern from her own family situation. At home there were so many children that there was a real rivalry for the parents' attention. However, by being good she received extra attention. Therefore, she was very frustrated at the foster home when she realized that each child received the same amount of affection. After many talks with her, the foster mother was able to convince A. O. that a person was loved for himself and not for the act he put on. This was said in special reference to the fact that A. O. frequently had sudden and prolonged laughing spells or hours when she would not talk at all.

The foster mother did not have a close contact with nine of the fifteen children. There were three reasons for this. First of all, three of the children had a very brief placement. Secondly, there were no outstanding problems in connection with four other children. Thirdly, the last two children would not allow the foster mother to become well acquainted with them. Their outward manner, at least, was one of poise and self-assurance. The foster mother did not find it necessary to push a relationship where the children did not seem to want it.

CHAPTER V.

CONCLUSIONS AND RECOMMENDATIONS

This thesis was undertaken in order to study the environmental adjustment made by fifteen rheumatic fever patients upon their discharge from the Church medical foster home and to determine what contributions the foster home made to this adjustment. The study was designed to determine (1) the school, work, and recreational activities engaged in by the children, (2) the personality factors of the foster mother which enabled her to understand and cope with some of the behavior problems presented by the children, (3) the particular areas of adjustment affected by the foster home experience, and (4) the factors which hindered the patients' adjustment after leaving the Church home.

Before interpreting the data secured through examination of the case records of the girls studied, a discussion of the meaning of illness to the patient was presented. Following this was a description of the physical factors involved in rheumatic fever as well as an evaluation of the foster home and the personality of the foster mother. It was felt that background material was essential for the better understanding of the cases.

The environmental adjustment of the rheumatic fever patients was studied in the following three categories of (1) education, (2) work experiences, and (3) recreational activities. Unfortunately, it was very difficult for the writer to obtain much information on the home adjustment of the children. The parents could more readily understand the writer's

interest in the school progress or health of their children. They were not inclined to speak freely on the subject of home adjustment.

In relation to their education only general and obvious questions were asked the patients. No detailed analysis was made of the past school history, nor were any of the schools visited. Eleven of the fifteen children received schooling at the foster home. There were four who did not receive any instruction. Two of the four had short term placements and the other two came during the summer months. A case illustration, which represented four other similar cases, was given to show how a disturbed family background prevented a good school adjustment before placement and how the foster home experience influenced this situation. This illustration pointed out the interaction of emotional, mental, and physical factors. The evidence seemed to indicate that a good foster home experience can give a disturbed child a certain amount of rest and security, even after discharge to her own home.

In the group of fifteen, eight were found to be still in public school, three in high school, two high school graduates, and one with a completion of two years of high school. The remaining child is receiving public school education in the foster home. All of the children attending school, with one exception, were promoted after their discharge from the foster home. The child who failed had to repeat the first grade. It is difficult to say whether the children were promoted because they were bright or because the quality of the schooling in the foster home was high. Eight of the children attending school have gone to their classes regularly while five have not done so. It is not easy to conclude exactly what the reasons

were in each case. Some of the factors certainly were health, intelligence, economic need, and personal ambition. Generally speaking, however, it can be said that the connection between school adjustment and emotional problems which beset the patient was obvious in the cases presented.

A case illustration was given which showed that a child can suffer a great deal if her teacher does not have the understanding or the knowledge regarding the illness of the child. The writer strongly recommends that teachers be instructed about rheumatic fever and its emotionally and physically crippling effects. This would certainly point the way toward a more thoughtful approach on the part of the teachers. It can also be added that schools and social agencies should make more definite efforts to understand each other's specific problems.

As far as vocational activities are concerned, the three girls of the group who are working seemed to have made a good adjustment. The writer used the following criteria to determine good adjustment: (1) satisfaction with job and with what is accomplished, (2) good adjustment with employer and employees, and (3) no physical or emotional exhaustion beyond natural fatigue. The physical conditions of these three girls seemed not to have stood in the way of their securing the jobs they desired. However, the writer can conceive that this is not always true. The general public associates a cardiac condition with the possibility of sudden death, and therefore, is reluctant to employ such a person. A revision of physical standards for employment selection is suggested. Since the war, many employees are coming to realize that handicapped people can do satisfactory work. A pre-employment physical examination can be used to determine a suitable job

for a handicapped worker. Public education is greatly needed in this area. A suggestion is made that these handicapped people, in quest of employment, be referred to the Vocational Rehabilitation Service.

Eleven of the fifteen children did not belong to any clubs at the time of this investigation. The reason given was that there were no recreational facilities available in their immediate neighborhood. Even though the cardiac must often limit her activity, it is vital that she have some recreation which is suited to the limitations set up by the physician. Recreation is most important because it provides a healthy outlet for excess energy. Two children of this group of eleven even had a hard time to resume friendships because the other children thought that rheumatic fever was contagious. This again points up the fact that education on the subject is greatly needed.

Four children were fortunate in having access to recreational activities. Their experiences did much to bolster their sense of security and personal worth.

The degree of family disturbance shown in the cases presented seems to indicate that some sort of case work would be valuable after the discharge of the patient from the foster home to her own home. The home supervision might be given by a social worker from the agency. On the other hand, an appropriate referral to another social agency might be indicated. The possible effectiveness of a social worker in the resolving of some of the difficulties encountered by the children in the areas of education and recreation should be an important consideration.

Inquiry into the emotional aspects of a long and serious illness

seems to indicate that there are many problems involved. During this illness the child is brought into a state of regression where he is dependent upon others for gratification and fulfillment of his needs. This is a pleasant state for the child in which he wishes to remain, provided his needs are adequately met. Eventually, he has to accept reality but a certain pattern of behavior remains. If a child, in later life, meets a disappointment or an obstacle, he often reacts by becoming ill, and frequently manifests many of the same symptoms as appeared during the childhood illnesses. Therefore, it would seem that an essential part of the treatment of a child with a serious illness lies in the management of his convalescence, both from physical and psychological standpoints.

Mrs. Jean Church, the foster mother discussed in this study, has, with the help of the various social workers of Children's Mission, kindly and firmly taught the patients that the goal for them is to achieve independence. Mrs. Church is a warm, motherly person, full of understanding. She is very reliable medically, and together with the social workers, interprets to the patient her medical program and gives reasons for clinic visits, blood tests, X-rays, and medications. The foster mother has knowledge of the emotional factors in illness and four cases were represented in order to point out her particular skill in handling the emotional problems which she encountered in the medical home. The writer would highly recommend that similar medical foster homes be established by other social agencies whose function includes foster home care for children. It is hoped that this study showed the therapeutic value of the Church home for the children in care there.

There is a necessity for better understanding regarding the long term needs of a person during convalescence. While a person is ill, he receives care in accordance with his needs and his acceptance of help. Once he has recovered from this illness, there is often difficulty in his readjustment because of a lack of comprehension on the part of the public as to the public's responsibility in such matters as employment, housing, and education.

Community contribution is needed which will be as adequate as the contribution made in the Church medical foster home. The status of the patient of rheumatic heart conditions would then indeed be adequately insured by supplementation of these roles.

THE END

Approved,

Richard K. Conant

Richard K. Conant
Dean

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APPENDIX

Schedule Used to Get Information from Agency Record

1. Name:
2. Address:
3. Age at placement:
4. School attended prior to placement:
5. Medical:
   a. Name of the hospital:
   b. Diagnosis:
   c. Prognosis:
6. Degree of family cohesion:

Schedule Used to Get Information from Foster Mother

1. Name:
2. Placement dates:
3. Medical history during placement:
4. Social adjustment in the foster home:
   a. Nature of interpersonal relationships with other children:
   b. Growth in personality--with special regard to individual problems:
   c. Degree of co-operation with foster mother, doctor, social worker, teacher, and occupational therapist:
5. School adjustment in the foster home:
6. Relationship between girl and foster mother after discharge:
7. Personality factors of the foster mother which particularly contributed to the growth of the girl:

Schedule Used to Get Information from Home Visit

1. Name:

2. School adjustment:

   a. School attendance or home teacher:

   b. Effect of physical handicap on regular attendance:

   c. Has return to school routine been difficult?

   d. Did subject matter seem unfamiliar or too advanced?

   e. Have principals, teachers, and fellow students been thoughtless in their remarks concerning the girl's absence or ability?

3. Work adjustment:

   a. Effect of physical handicap on type of work the girl was able to secure:

   b. Effect of physical handicap on quality of work done by the girl:

   c. Degree of difficulty there existed in the establishment of interpersonal relationships with employer and fellow employees:

4. Home adjustment:

   a. Has the girl been able to find her place in the family unit? Has she lost her former status to another member?

   b. Has she been able to resume friendships?

   c. How has the family welcomed her back?

   d. What is the present home situation regarding:

      (1) physical conditions:

      (2) financial circumstances:

5. Recreation--what sort does the girl engage in?